# MONTANA BOARD OF SPEECH-LANGUAGE PATHOLOGISTS AND AUDIOLOGISTS

301 South Park, 4th Floor
PO Box 200513
Helena Montana 59620-0513
Phone: (406) 841-2385 Fax: (406) 841-2305
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### AIDE REGISTRATION REQUIREMENTS AND APPLICATION INSTRUCTIONS

Incomplete applications will be returned with a statement regarding incomplete portions.
Once an application is complete, estimated time for issuance of registration card is 7 days.

## AUDIOLOGIST AIDE or SPEECH-LANGUAGE PATHOLOGIST AIDE REGISTRATION

**Qualifications for Registration:** Applicants for aide registration must:

- ✓ Aide must be supervised by a current Montana licensed speech-language pathologist or audiologist.
- ✓ Each speech-language pathologist aide or audiology aide must annually register with the board on or before October 31.
- ✓ Applicants must submit a fully completed and signed aide registration form.

**Fees:**

- ✓ $30.00 Application fee
- ✓ $20.00 Additional Late registration fee after October 31

Make check or money order payable to the Board of Speech-Language Pathologists and Audiologists. All fees are non-refundable. Do not send cash

**REGISTRATION APPLICATION PROCEDURES:** A fully-completed application for registration, signed and notarized, shall be submitted with the following:

- Aide 1 applicants must submit proof of enrollment in a graduate program
- Aide 2 applicants must identify date and major of BA degree.
- Aide 3 applicants do not require a degree.
- Signature of the aide applicant, the current Montana licensed speech-language pathologist or audiologist supervisor and the representative of the hiring agency.
- The supervisor is also required to fill out sections of the aide registration form.
- Aides must register annually.
- Registered aides are not licensed practitioners.

- Supervision Requirements:

Aide 1 = 30% while performing diagnostic and interpretive functions in the first year of activities. 5% client contact time of which 2% shall be direct contact
Aide 2 = 10% of client contact time of which 5% shall be direct contact
Aide 3 = 20% of client contact time of which 10% shall be direct contact

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**WEBSITE: www.discoveringmontana.com/dli/slp**

## ANNUAL AIDE REGISTRATION FORM

**REGISTRATION #:** _____
**PLEASE TYPE OR PRINT IN INK.**
(Please allow an average of 10 days for processing from the date that the Board has a completed application)

**APPLICANT INFORMATION:**

1. FULL NAME: _____
   Last First Middle

2. MAILING ADDRESS _____
   Street or PO Box # City and State Zip

3. TELEPHONE (____) _____ (____) _____
   Business Home

4. SOCIAL SECURITY NUMBER _____

5. DATE OF BIRTH _____ PLACE OF BIRTH _____ ☐ MALE ☐ FEMALE
   City/State

6. NAME FOR REGISTRATION CARD: _____
   State your name as it should appear on the registration card.)

**EMPLOYMENT INFORMATION:**

7. NAME OF EMPLOYER: _____ PHONE: _____
   SCHOOL DISTRICT/AGENCY

8. EMPLOYER ADDRESS: _____
   Street or PO Box # City and State Zip

9. ANTICIPATED DATES OF EMPLOYMENT: FROM _____ TO _____
   MONTH/DAY/YEAR MONTH/DAY/YEAR

**AIDE LEVEL: Speech:** ____ **Audiology:** ____ ☐ **AIDE 1** ☐ **AIDE 2** ☐ **AIDE 3**

**AIDE 1:** Attach current proof of enrollment in a graduate program:

*SUPERVISION*
A minimum of 30% while performing diagnostic and interpretive functions in the first year of non-allowable activities. The supervision requirement will be 5% of client contact time, of which 2% shall be direct contact after the first year, at the discretion of the supervising speech-language pathologist.

Is this the first year that you have been registered as Aide 1? ☐ Yes ☐ No
Total number of hours per month with clients _____ X 5% = _____ direct contact hours

**AIDE 2:** What is your BA in? _____ Date of Degree: _____

*SUPERVISION*
Total number of hours employed as a Speech or Audiologist Aide 2
per month _____ X 10% equals _____ indirect client contact hours

Total number of hours per month with clients _____ X 5% = _____ direct contact hours
(10% of client contact time of which 5% shall be direct contact)

**AIDE 3:** No graduate degree in communication sciences and disorders.

*SUPERVISION*
Total number of hours employed as a Speech or Audiologist Aide 3
per month _____ X 20% equals _____ indirect client contact hours

Total number of hours per month with clients _____ X 10% = _____ direct contact hours

## SUPERVISOR INFORMATION

NAME: _____ License #: _____
First Last

MAILING ADDRESS: _____
Street or PO Box # City and State Zip

TELEPHONE ( ) _____ ( ) _____
Business Home

EMPLOYING AGENCY : _____

Amount of hours of supervision provided to aide per month: _____
How many hours of this time is spent in direct supervision of the aide with a client? _____ hours

**I now supervise** _____ **aides, which equals** _____ **FTE's** (ARM 8.62.502(5))

IF THERE IS A SIGNIFICANT CHANGE IN SUPERVISION PLAN OR IF THERE IS A DISAGREEMENT BETWEEN THE SUPERVISOR, AIDE or EMPLOYING AGENCY, THE BOARD MUST BE NOTIFIED IN WRITING. (ARM 8.62.502(4))

## SUPERVISOR INFORMATION FORM

The Supervisor Information Form must accompany all Aide Registration Forms.

Supervisor's Name _____

| Aide's Name | Time aide works | Hours of supervision | Aide caseload |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |

SUPERVISOR:

Other assigned duties: _____

_____

Supervisor's own caseload: _____

_____

Supervisor's Administrative duties: _____

_____

Approximate travel time per month: _____

I HAVE READ, REVIEWED AND HAVE AGREED TO FOLLOW THE ABOVE PROPOSED PLAN AND THE ADMINISTRATIVE RULES OF THE BOARD.

DATE _____ _____
SIGNATURE OF SPEECH PATHOLOGY AND/OR AUDIOLOGY AIDE

DATE _____ _____
REPRESENTATIVE OF HIRING AGENCY

**`THE MID YEAR FORM WILL BE AN AFFIDAVIT ON THE LICENSEE/SUPERVISOR RENEWAL FORM**
SCHEDULE INFORMATION: RULE NUMBERS 8.62.501, 8.62.502, AND 8.62.504
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## AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Board of Speech-Language Pathologists and Audiologists. I hereby declare under penalty of perjury the information included in the aide application and supervisor information to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement may lead to denial of the aide application or subsequent revocation of annual registration on ethical grounds. I have read and will abide by the current statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

_____ _____
Legal Signature of Licensed Supervisor Dated

Subscribed and sworn to before me this _____ day of _____, _____ at _____.
City/State

SEAL _____
Signature of Notary Public

_____
Notary Public Printed Name

For the State of _____ My commission expires _____